



AESTHETIC DENTISTRY  
*of Georgetown*

## GUEST REGISTRATION

### PERSONAL INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Marital Status (Circle One) S M Gender (Circle One) M F  
EMAIL ADDRESS \_\_\_\_\_

### POLICY HOLDER INFORMATION

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Dental Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

### WHOM MAY WE THANK FOR REFERRING YOU?

Family Member/Friend \_\_\_\_\_ Doctor \_\_\_\_\_  
Internet/Google \_\_\_\_\_ Social Media \_\_\_\_\_  
Mailer/Magazine \_\_\_\_\_ Drive-By \_\_\_\_\_  
Other-Specify \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_



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### **MEDICAL HISTORY**

Do you have any of the following?

Yes/No

Yes/No

Yes/No

\_\_\_\_ Any heart problems  
\_\_\_\_ Abnormal blood pressure  
\_\_\_\_ Stroke  
\_\_\_\_ Circulatory problems  
\_\_\_\_ Excessive bleeding  
\_\_\_\_ Anemia  
\_\_\_\_ Arthritis  
\_\_\_\_ Respiratory problems  
\_\_\_\_ Epilepsy  
\_\_\_\_ Diabetes

\_\_\_\_ Hepatitis A (infectious)  
\_\_\_\_ Hepatitis B (serum)  
\_\_\_\_ Jaundice  
\_\_\_\_ Malignancies  
\_\_\_\_ Rheumatic fever  
\_\_\_\_ Unfavorable reaction to  
dental anesthetic  
\_\_\_\_ Fainting tendency  
\_\_\_\_ Tuberculosis  
\_\_\_\_ Thyroid disease

\_\_\_\_ Glaucoma  
\_\_\_\_ AIDS/HIV  
\_\_\_\_ Blood Transfusion  
\_\_\_\_ Sinus Problems  
\_\_\_\_ Botox Use  
\_\_\_\_ Do you use tobacco  
How often \_\_\_\_\_  
\_\_\_\_ Are you a nursing mother  
\_\_\_\_ Are you pregnant  
Due Date \_\_\_\_\_

Do you have a history of: rheumatic fever, heart murmur, artificial valve or joint replacement which now requires premedication?(circle which one) comments: \_\_\_\_\_

Are you allergic to any drugs? \_\_\_\_\_ Please list \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Please list \_\_\_\_\_

Have you taken medication for bone density or Osteoporosis? \_\_\_\_\_ Please list \_\_\_\_\_

Are there any other medical conditions of which I should be aware? \_\_\_\_\_

Are you presently under the care of a physician? Y or N If so, for what? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ What for? \_\_\_\_\_

Do you have a family history of heart disease, diabetes, or periodontal disease? \_\_\_\_\_

Are you waking up frequently during the night? \_\_\_\_\_ Do you wake up with headaches? \_\_\_\_\_

Have you ever been treated for snoring or sleep apnea? \_\_\_\_\_ Have you had a sleep study? \_\_\_\_\_

Date of study \_\_\_\_\_ Have you ever used a CPAP? \_\_\_\_\_ If so, was it successful? \_\_\_\_\_

### **DENTAL HISTORY**

Are you currently experiencing a toothache or any other pain in your head or neck? If so, please describe: \_\_\_\_\_

Date of your last dental treatment or cleaning? \_\_\_\_\_ Date of last dental X-rays? \_\_\_\_\_ What type? \_\_\_\_\_

Would you change anything about the appearance of your smile? \_\_\_\_\_

Do you have any of the following:

Yes/No

Yes/No

Yes/No

\_\_\_\_ Periodontal disease  
\_\_\_\_ Abscesses  
\_\_\_\_ Sores (Ulcers)  
\_\_\_\_ Cold sores/Fever blisters

\_\_\_\_ Halitosis (Bad breath)  
\_\_\_\_ Sensitivities (Hot, Cold  
Sweets, Biting)  
\_\_\_\_ Headaches

\_\_\_\_ Bruxism (Grinding teeth)  
\_\_\_\_ Clicking/Popping TMJ  
\_\_\_\_ Pain/fatigue in jaw joint  
\_\_\_\_ Dizziness

Are there any other conditions or experiences of which I should be made aware of? \_\_\_\_\_

Guest Signature

Date



## FINANCIAL POLICY

We are pleased that you have chosen Dr. Holley for your dental needs. In order to better inform you, please read the following summary of our financial policy.

### Insurance

You, as the patient, are responsible for all charges regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. We provide services as an out of network provider, and as a courtesy we are happy to file claims with your primary insurance company for services rendered. Your deductible, co-payment, and/or co-insurance are due at the time of service. However, if we have not received payment from your insurance company within 60 days from the date of the service, you will be expected to pay the balance in full.

### Payment

We realize that patients have financial needs, and we will do our best to find a solution that will work best for you. We accept Visa, MasterCard, American Express, Discover, Care Credit, and personal checks with proper identification. Returned checks may be recovered electronically along with the state allowed recovery fee. Payment of co-insurance, deductible, and/or co-payment is required at the time the services are rendered unless other arrangements have been made in advance. There will be a \$30 fee assessed for returned checks and accounts sent to collections. Patients with outstanding balances 60 days or more overdue must make arrangements for payment prior to scheduling future appointments.

### Missed Appointments/Late Cancellations

Your appointment is time set aside especially for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office and speak to an appropriate coordinator 24 hours prior to your appointment if you must cancel or reschedule. Unfortunately, if the required notice is not given, you will be charged a Late Cancellation/No Show Fee. Excessive abuse of this policy may result in discharge from the practice.

I have read and understand Dr. Holley's financial policy. I agree to assign insurance benefits to Dr. Holley when necessary. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date